Location of Medication:

ANAPHYLAXIS ACTION PLAN

Student Name: _____ D.O.B: _____ Grade: _____

********** Healthcare provider to complete remainder of this page except parent signature below**********

Allergy to: _____

Weight: _____ lbs. Asthma ☐ Yes (higher risk of a severe reaction ☐ No

ANY SEVERE SYMPTOMS AFTER SUSPECTED OR KNOWN INJESTION/ALLERGEN EXPOUSRE:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	"Tight", hoarse, trouble breathing or swallowing
MOUTH:	Swelling of tongue, lips or back of throat
SKIN:	Many hives over body

OR a **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY!!!** (see back for injection technique)
   ☞ _____**Epi Brand/dose**
2. **CALL 911** then call parent and school nurse (see back for contact numbers)
3. **Begin monitoring (see box below)**
4. **Give additional medications as noted below**

☞ _____ (antihistamine brand/dose)

☞ _____ (inhaler/bronchodilator brand/dose)

Antihistamines and/or inhalers are not to be depended upon to treat anaphylaxis. USE EPINEPHRINE

MILD SYMPTOMS ONLY:

Mouth:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itching, local swelling around sting site

1. **GIVE** ☞ _____ (antihistamine brand/dose)
2. Stay with student, monitor symptoms and notify parent and school nurse.
3. **If symptoms progress (see above) USE EPINEPHRINE, CALL 911 and monitor as noted below**

MONITORING: Stay with student. Tell emergency services that epinephrine was given. Note time given. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or reoccur. For a severe reaction, consider keeping student lying on back with legs raised.

If Applicable

- ☐ Student may carry medication AND self-medicate without supervision. As the medical provider, I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on their own without school personnel supervision.
- ☐ Student may carry medication but without intent to self-medicate. School staff will assist.
- ☐ An additional supply of medication is prescribed so that student can carry medication AND school office receives a medication supply from parent.

_____/_____/_____
Health Care Provider Signature **DATE** **Phone Number**

_____
Health Care Provider PRINTED NAME

_____/_____
Parent/Guardian Signature **Date**

Parent: See back of form to complete for contact numbers and permission (for student self-carry if applicable)

Form adapted June 2013 from Food Allergy Action Plan 5/2013, www.foodallergy.org, Food Allergy Research and Education (FARE)

Contact Numbers

Parent/Guardian Numbers:

1st: _____
Name Number

2nd: _____
Name Number

3rd: _____
Name Number

School Nurse Contact: School will complete

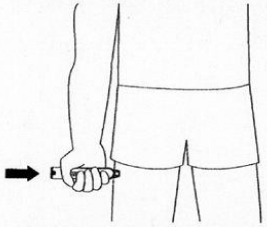
1st: _____
Name Number

2nd: _____
Name Number

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- **First, remove the EPIPEN Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**

- **Hold orange tip near outer thigh (always apply to thigh)**

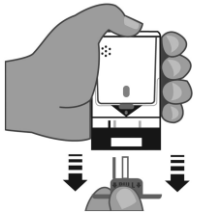


- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds**

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15 mg

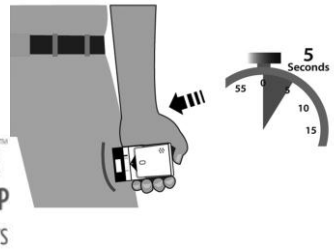
Auvi-Q™ (Epinephrine Injection USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.



Pull off RED safety guard.

Place black end against outer thigh, then press firmly and hold for 5 seconds.



For students who carry and/or self-administer medications: Authorization by parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian: See generally Mont. Code Ann. § 20-5-420

As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm this student has been instructed by his/her healthcare provider on the proper use of this/these medication(s). He/she has demonstrated to me he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

- I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
- I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma, severe allergy, or anaphylaxis emergency. I have provided the following backup medication: _____
- I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.
- I understand it is my responsibility to pick up any unused medication at the end of the school year, and any medication not picked up may be disposed of.
- I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent/Caretaker/Guardian relative signature: _____ Date: _____